IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
DELTA DIVISION

LOIS LAMB,
Plaintiff

V. NO. 2:93CV40-B-D

PROVIDENT INSURANCE COMPANY,
Defendant

MEMORANDUM OPINION

This cause comes before the court on the defendant's motion to dismiss or, in the alternative, for summary judgment. The court has duly considered the parties' memoranda and exhibits and is ready to rule.

INTRODUCTION

The plaintiff alleges that the defendant in bad faith refused to pay a claim under an employee benefit plan subject to the provisions of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001, et seq. The defendant moves to dismiss for failure to exhaust administrative remedies and, in the alternative, for summary judgment on the ground that the insured's dependent was not eligible for coverage at the time the medical expenses were incurred.

FACTS

The following facts are undisputed. The plaintiff was an insured under a group health and accident policy issued by the defendant to all employees of Panola Mills, Inc. [Panola Mills].

The policy extends coverage to dependent children of the named insured who are under the age of 19 years; dependent children between the ages of 19 and 24 who are full-time students are also eligible. Additional premiums were withheld from the plaintiff's paycheck for dependent coverage of her son, Dennis Gregory Lamb. On February 12, 1987, Panola Mills distributed to its insured employees a memo stating in part:

> When your child turns 19 and is no longer in school, it is important that you tell [Panola Mills' insurance clerk] immediately. VERY IMPORTANT....Please sign your name, acknowledging that you will try to keep us informed of your changes.

The plaintiff signed her name on the memo. The plaintiff's son reached his 19th birthday on January 7, 1990. On June 4, 1991 the plaintiff's son sustained injuries resulting in medical expenses for which the plaintiff seeks insurance benefits. The plaintiff's son had reached the age of 20 and was not a full-time student.

The plaintiff's uncontroverted affidavit states that on June 6, 1991 she notified Panola Mills's insurance clerk of her son's injuries and that he would be incurring medical expenses for which coverage was sought. The affidavit further states that the clerk concluded that she was not eligible for benefits since her son had reached the age limit and advised her "that no claim would be filed on her behalf." The defendant continued to accept additional premiums for dependent coverage through March 28, 1992, more than two years after the plaintiff's son reached the age limit and

approximately ten months after the above-referenced notice was given to Panola Mills.

On April 21, 1992 the plaintiff's counsel sent a letter to the defendant's claim office, stating in part:

> [The plaintiff] has been told by Panola Mills that her son was presumably automatically dropped from coverage after reaching his 18th birthday. However, premiums have continued to be taken out of her check to provide coverage for her son, who is now 21 years of age.
>
> [The plaintiff] recently notified Panola Mills of her intentions to file a claim under this policy to cover medical expenses incurred by her son. She was told at that time that there was no coverage due to the fact that he was over the age of 18. It is my position that since she continued to pay premiums on her son that the policy remained in effect and that she is entitled to receive benefits under the policy. I would appreciate your letting me know what Provident's position will be with respect to this claim.

The defendant made no response to the letter. On February 16, 1993 the plaintiff filed the complaint in this cause. During the course of discovery the plaintiff provided an itemization of medical bills. The defendant subsequently notified the plaintiff's counsel that no claim had been filed and the plaintiff requested the document the defendant contends is the proper claim form. On September, 16, 1993, the defendant, for the first time, provided the plaintiff with a copy of the claim form. On September 20, 1993 the plaintiff filed with Panola Mills the claim form furnished by the defendant. The defendant made no response to the claim. In

November, 1993 the defendant tendered the total of excess premiums paid by the plaintiff.

ERISA PREEMPTION

The complaint alleges state law claims of breach of contract, negligent and intentional infliction of emotional distress, and bad faith and seeks recovery of compensatory and punitive damages, as well as insurance proceeds. The defendant moves for dismissal of these claims on the ground of ERISA preemption. 29 U.S.C. § 1144(a). The plaintiff concedes that "her claims for bad faith are preempted by ERISA," but asserts that she is entitled to medical benefits, attorney's fees and costs. Attorney's fees and costs are available under ERISA, 29 U.S.C. § 1132(g)(1). The court finds that the plaintiff's state law claims, including bad faith, are preempted by ERISA. E.g., Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 95 L.Ed.2d 39 (1987) (bad faith and punitive damages preempted by ERISA); Medina v. Anthem Life Ins. Co., 983 F.2d 29, 32-33 (5th Cir.), cert. denied, 126 L.Ed.2d 35 (1993) (extracontractual and punitive damages claims preempted).

EXHAUSTION

The defendant moves to dismiss on the grounds that the plaintiff failed to file a written claim for insurance benefits and exhaust administrative remedies prior to filing this action. Denton v. First Nat'l Bank, 765 F.2d 1295, 1303 (5th Cir. 1985) ("Congress, in enacting ERISA, clearly wanted potential plaintiffs

to first exhaust their administrative remedies before resorting to the federal courts"). The Fifth Circuit has held that, under certain circumstances, an insured may not make his initial claim for benefits by filing a lawsuit. Medina, 983 F.2d at 33; Meza v. General Battery Corp., 908 F.2d 1262, 1279 (5th Cir. 1990). The court in Meza concluded that the policies underlying the exhaustion doctrine

> require claimants to make some attempt at obtaining their benefits through the administrative route, or, at the very least, to make some effort to learn of the procedures applicable to them.

908 F.2d at 1279. The claimant did not receive a copy of a Plan Summary, as required by ERISA, but did not allege or establish that any failure on the part of his former employer or insurer to provide plan information precluded him from pursuing his administrative remedies or prejudiced his ability to obtain plan benefits. Id. at 1279, 1280. Since the claimant neither requested plan information nor applied for benefits prior to bringing suit, the court held that the claimant, under the circumstances, was not excused from the exhaustion requirement. Id. at 1279. In Medina the insured had previously filed claims and received proceeds but failed to file a claim for the disputed sum. 983 F.2d at 33. The court noted that the claimant "obviously knows how [the insurer's] claims procedure operates." Id.

According to her affidavit, the plaintiff attempted to promptly file a claim through her employer's insurance clerk but was told no dependent coverage existed and that no claim would be filed on her behalf. Through counsel, the plaintiff directly advised the defendant of her claim and requested communication of its position with respect to the claim. The defendant neither responded nor furnished the plaintiff with a claim form. Clearly, the plaintiff made "some attempt at obtaining [her] benefits through the administrative route." The record before the court reflects that the plaintiff made two attempts to do so.

The defendant contends that this action is premature under the policy provision prohibiting filing of suit "before the end of 60 days after proof of loss has been furnished." The defendant did not furnish the plaintiff a proof of loss form even after notice of her claim in the April, 1992 letter. The plaintiff asserts that the defendant in its defenses has in effect denied the plaintiff's claim. The defendant's denial is further manifested by its refund of the excess premiums for dependent coverage. The court finds that the insured was impeded from pursuing administrative remedies before filing this action and is therefore excused from the exhaustion requirement.

WAIVER

The defendant contends that the plaintiff's son was not an eligible dependent at the time the medical expenses were incurred

under the age limit provision in the policy. The plaintiff contends that the defendant waived its right to deny benefits by accepting the excess premiums over two years after the plaintiff's son had reached the age limit. 29 U.S.C. § 1132(a)(3) reads in part:

> A civil action may be brought...by a participant, beneficiary or fiduciary...to obtain other appropriate equitable relief.

ERISA "must be interpreted under principles of federal substantive law." Brown v. American Internat'l Life Assurance Co., 778 F. Supp. 912, 917 (S.D. Miss. 1991). "Congress intended for courts to fashion a federal common law governing employee benefit plans." Pitts v. American Sec. Life Ins. Co., 931 F.2d 351, 355 (5th Cir. 1991). The power to develop federal common law in ERISA actions "extends only to areas that federal law preempts[1] but does

---

[1] The plaintiff relies on Miss. Code Ann. § 83-9-15 which reads in part:

> If any such policy contains a provision establishing, as an age limit or otherwise, a date after which the coverage provided by the policy will not be effective, and if such date falls within a period for which premium is accepted by the insurer or if the insurer accepts a premium after such date, the coverage provided by the policy will continue in force, subject to any right of cancellation, until the end of the period for which premium has been accepted.

§ 83-9-1 defines "policy of accident and sickness insurance, as used in Sections 83-9-1 through 83-9-21," as "any individual or group policy or contract of insurance against loss resulting from sickness or from bodily injury...." The definitional section appears on its face to be inconsistent with § 83-9-17 which reads in part:

not address." Rodrigue v. Western and Southern Life Ins. Co., 948 F.2d 969, 971 (5th Cir. 1991). Both parties refer to waiver and estoppel interchangeably. The Fifth Circuit has stated:

> Although waiver and estoppel are sometimes used interchangeably, especially in the law of insurance, there is a subtle but significant legal distinction between the two....Strictly defined, waiver describes the act, or the consequences of the act, of one party only, while estoppel exists when the conduct of one party has induced the other party to take a position that would result in harm if the first party's act were repudiated.... Waiver is the voluntary or intentional relinquishment of a known right.

Pitts, 931 F.2d at 357. The insurer in Pitts accepted premium payments for only one employee although the ERISA policy required a minimum of ten employees. The court held in part that the insurer waived its right to assert its defense by accepting premiums "for five months after learning beyond all doubt that Pitts was the only employee remaining on the policy" and cashing the five checks after giving notice of termination. Id. at 354, 357.

The defendant contends that Pitts is contrary to the estoppel line of cases. E.g., Degan v. Ford Motor Co., 869 F.2d 889, 893

> Nothing in sections 83-9-1 to 83-9-21 shall apply to or affect...(3) any blanket or group policy of insurance....

It is undisputed that the plaintiff's policy is a group policy. In any event, § 83-9-15 is preempted by ERISA "insofar as [it] may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a).

(5th Cir. 1989) (alleged oral assurances of early retirement benefits). The court in Degan held that "ERISA precludes oral modifications to benefit plans and that claims of promissory estoppel are not cognizable in suits seeking to enforce rights to pension benefits." Id. at 895. The court in Rodrigue held that the insurer's oral authorization of the insured's hospital admission for certain treatment, expressly excluded from the ERISA policy, did not equitably estop the insurer's denial of coverage on the ground of oral modification. 948 F.2d at 972. The Fifth Circuit has determined that ERISA addresses "the question of amendment" by requiring that "employers establish and maintain benefit plans according to a written instrument which establishes procedures for amendment and specifies those authorized to make amendments." Williams v. Bridgestone/Firestone, Inc., 954 F.2d 1070, 1072 (5th Cir. 1992) (citing 29 U.S.C. § 1102(a)(1) and (b)(1)). Accordingly, ERISA

> preempts state law claims, based on breach of contract, fraud, or negligent misrepresentation, that have the effect of orally modifying the express terms of an ERISA plan and increasing plan benefits for participants or beneficiaries who claim to have been misled.

Memorial Hospital System v. Northbrook Life Ins. Co., 904 F.2d 236, 238, 245 (5th Cir. 1990).

In developing federal common law "to supplement the statutory scheme," the court may use state common law consistent with the policies underlying ERISA. Cefalu v. B.F. Goodrich Co., 871 F.2d

1290, 1297 (5th Cir. 1989). Waiver does not involve oral modification of the policy and is not contrary to any mandate or rationale underlying ERISA. See Minnesota Mut. Life Ins. Co. v. Larr, 567 So.2d 239, 241-42 (Miss. 1990) (an agent's oral agreement to extend the scope of coverage is distinguishable from an insurer's waiver of an age limitation by acceptance of premiums). Since Pitts involves the separate and distinct doctrine of waiver, it is not inconsistent with the Degan line of cases. Therefore, Pitts is controlling.

Generally, waiver requires proof of the defendant's "knowledge, actual or constructive, of the existence of his rights or of all the material facts." 18 Couch on Insurance 2d §71:14 (2d ed. 1983). E.g., Larr v. Minnesota Mut. Life Ins. Co., 924 F.2d 65, 66-67 (5th Cir. 1991) (construing Mississippi law) (constructive knowledge based on the disclosure of the insured's age and birth date in his insurance application). The defendant asserts that the plaintiff assumed the burden of advising her employer when her son reached the age limit and failed to do so. However, the defendant continued to accept premiums for ten months after the employer learned that the plaintiff's son had reached the age limit. "The question of waiver is ordinarily one of fact." Id. at 66. Since the doctrine of waiver is not barred in ERISA actions, the court finds that the motion for summary judgment should be denied.

CONCLUSION

For the foregoing reasons, the plaintiff's state law claims should be dismissed on the ground of ERISA preemption. With respect to the ERISA claim, the defendant's motion to dismiss or, in the alternative, for summary judgment should be denied.

An order will issue accordingly.

THIS, the _____ day of October, 1994.

_____
NEAL B. BIGGERS, JR.
UNITED STATES DISTRICT JUDGE